Please fax completed form to WILLIAM LAND SCHOOL at 916-264-4357

H.F. 5
Rev. 12/13

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Health Services Office

This side to be completed by DOCTOR

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: this form must be completed each school year or more frequently, if necessary.

I. Basic Legal Provision - California Education Code, Section 49423

Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the name of the medication, method of administration, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

Designated school personnel may administer medication to pupils upon written request of the pupil's parent/guardian and physician **only** when the medication is in the original container.

II. Physician Instructions

Student _____ Age _____ Birth date _____

School _____ Grade _____

TO PHYSICIAN: Please note: Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

MEDICATION(S)	DOSAGE	ROUTE OF ADMINSTRATION	APPROXIMATE TIME OF DAY

Diagnosis or indication for medication _____

Length of time to be taken _____

Precautions or additional instructions _____

a. For emergency medication, is the student capable of self-administering the necessary treatment/medication? ☐ Yes ☐ No
b. Will the student need to carry this medication on his/her person? ☐ Yes ☐ No
c. Will the student need to self-administer this medication? ☐ Yes ☐ No

Please note obvious side effects to this particular medication _____

_____

Signature of Physician _____ Address _____

Print/Type Physician's Name _____ Phone _____ Date _____

This side to be completed by **PARENT**

III. Parent Request

Please check one of these boxes.

☐ I/We the undersigned, who am/are the parent(s) of _____ request that medicine be administered to said child by a designated member of the school staff, in accordance with the instructions outlined here and signed by our physician. The medication is to be given at _____ (time) with the following special instructions: _____

_____

☐ As indicated here in our physician's statement, our child, _____, will self-administer his/her own medication when required and we are not requesting school personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her medication at school because he/she suffers from _____ (state nature of illness). Our child will need to take his/her medication _____ (number of times per day) with the following special instructions: _____

_____

_____

_____

I/We hereby release, discharge and hold harmless Sacramento City Unified School District and its officers, agents and employees for any and all claims of civil liability arising out of an act or omission that causes our child to suffer an adverse reaction as a result of his/her self-administering medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents, and that we are required to personally bring the medication to school for students kindergarten through 8th grade. We understand that students in grades 9 through 12 may bring their own medication to the school office.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Home Phone	Work Phone

_____

Address

Emergency contact: _____ Phone: _____